DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

| TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL<br><br>FOR: HEALTH CARE FINANCING ADMINISTRATION | 1. TRANSMITTAL NUMBER:<br>**03-22** | 2. STATE<br>**New York** |
|---|---|---|
| | 3. PROGRAM IDENTIFICATION: **TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)** | |
| TO: REGIONAL ADMINISTRATOR<br>HEALTH CARE FINANCING ADMINISTRATION<br>DEPARTMENT OF HEALTH AND HUMAN SERVICES | 4. PROPOSED EFFECTIVE DATE<br>**April 1, 2003** | |

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

| 6. FEDERAL STATUTE/REGULATION CITATION:<br>42 CFR Part 447, Subpart C | 7. FEDERAL BUDGET IMPACT:<br>a. FFY **4/01/03 – 9/30/03 ($76,780,000.)**<br>b. FFY **10/01/03 – 9/30/04 ($153,550,000.)** |
|---|---|
| 8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:<br><br>**Attachment 4.19-D, Page 33(a), 47(x)(4), 47(x)(9), 47(x)(11), 47(x)(12), 47(x)(13), 47(x)(14), and 51(a)(1)** | 9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:<br><br>**Attachment 4.19-D, Page 33(a), 47(x)(4), 47(x)(9), 47(x)(11), 47(x)(12), 47(x)(13), 47(x)(14), and 51(a)(1)** |

10. SUBJECT OF AMENDMENT:
**Long Term Care Services**

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☒ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

| 12. SIGNATURE OF STATE AGENCY OFFICIAL:<br>Kathryn Kuhmerker | 16. RETURN TO:<br>**New York State Department of Health, Corning Tower, Empire State Plaza, Albany, New York 12237** |
|---|---|
| 13. TYPED NAME: **Kathryn Kuhmerker** | |
| 14. TITLE: **Deputy Commissioner Department of Health** | |
| 15. DATE SUBMITTED:<br>June 30, 2003 | |

**FOR REGIONAL OFFICE USE ONLY**

| 17. DATE RECEIVED: | 18. DATE APPROVED:<br>FEB 20 2004 |
|---|---|
| PLAN APPROVED – ONE COPY ATTACHED | |
| 19. EFFECTIVE DATE OF APPROVED MATERIAL:<br>APR – 1 2003 | 20. SIGNATURE OF REGIONAL OFFICIAL:<br>Burton Smith |
| 21. TYPED NAME: Charlene Brown | 22. TITLE: Deputy Director, CMSO |

23. REMARKS:

FORM HCFA-179 (07-92)

**New York**
**33(a)**

**Attachment 4.19-D**
**(04/03)**

For the purposes of establishing the indirect component of the rate of payment for services provided on or after April 1, 1995 through March 31, 1999 and for services provided on or after July 1, 1999 through March 31, [2003] 2005 the reimbursable base year costs as reported in the fiscal services and administrative services functional cost centers as specified in subparagraphs (i) and (ii) of this paragraph of a provider of services, excluding a provider of services reimbursed on an initial budget basis, shall not, except as otherwise provided in this paragraph, exceed the statewide average of total reimbursable base year administrative and fiscal service costs. For the purposes of this paragraph, reimbursable base year administrative and fiscal service costs shall mean those base year administrative and fiscal services costs remaining after application of all other efficiency standards, including but not limited to, peer group ceilings or guidelines. Effective for rates of payment commencing July 1, 2000, a separate statewide average of total reimbursable base year administrative and fiscal services costs shall be determined for each of those facilities wherein eighty percent or more of its patients are classified with a patient acuity equal to or less than .83 which is used as the basis for a facility's case mix adjustment. For the period July 1, 2000 through March 31, 2001, the total reimbursable base year administrative and fiscal services costs of such facilities shall not exceed such separate statewide average plus one and one-half percentage points. For annual periods thereafter through March 31, [2003] 2005, the total reimbursable base year administrative and fiscal services costs of such facilities shall not exceed such separate statewide average. In no event shall the calculation of this separate statewide average result in a change in the statewide average determined pursuant to this paragraph. The limitation on reimbursement for provider administrative and general expenses provided by this paragraph shall be expressed as a percentage reduction of the operating cost component to the rate promulgated for each residential health care facility.

TN 03-22 Approval Date FEB 2 0 2004

Supersedes TN _____ Effective Date APR - 1 2003

(x) Residential health care facility rates of payment for services provided on or after July 1, 1995 through March 31, 1996 shall be reduced by the Commissioner to reflect the elimination of operational requirements previously mandated by law or regulation or the Commissioner or other governmental agency, by a factor determined as follows:

(i) an aggregate reduction shall be calculated for each residential health care facility as the result of (a) up to fifty-six million dollars on an annualized basis for 1995, trended to the rate year by the trend factor for projection of reimbursable costs to the rate year, multiplied by (b) the ratio of patient days for patients eligible for payments made by government agencies provided in a base year two years prior to the rate years by a residential health care facility, divided by the total of such patient days summed for all residential health care facilities; and

(ii) the result for each residential health care facility shall be divided by such patient days for patients eligible for payment made by governmental agencies provided in the residential health care facility, for a per diem reduction in rates of payment for such residential health care facility for patients eligible for payments made by governmental agencies.

(iii) Effective April 1, 1996 through March 31, 1999 and on or after July 1, 1999 through March 31, [2003] <u>2005</u> residential health care facility rates of payment shall be reduced by an annual aggregate amount of fifty-six million dollars to encourage improved productivity and efficiency. Actual reduction in rates within such aggregate amounts will be allocated among facilities based upon each facility's ratio of Medicaid utilization to total statewide Medicaid utilization for all residential health care facilities.

facility days of care provided to beneficiaries of Title XVIII of the federal social security act (Medicare), divided by the sum of such days of care plus days of care provided to residents eligible for payments pursuant to title 11 of article 5 of the social services law minus the number of days provided to residents receiving hospice care, expressed as a percentage, for the period commencing January 1, 1999 through November 30, 1999 based on such data for such period. This value shall be called the 1999 statewide target percentage.

(f) Prior to February 1, 2001, February 1, 2002, February 1, 2003, [and] February 1, 2004, February 1, 2005, and February 1, 2006, the [c]Commissioner of [h]Health shall calculate the result of the statewide total of residential health care facility days of care provided to beneficiaries of title XVIII of the federal social security act (Medicare), divided by the sum of such days of care plus days of care provided to residents eligible for payments pursuant to title 11 of article 5 of the social services law minus the number of days provided to residents receiving hospice care, expressed as a percentage, for the period commencing January 1, through November 30, of the prior year respectively, based on such data for such period. This value shall be called the 2000, 2001, 2002, [and] 2003, 2004 and 2005 statewide target percentage respectively.

(2) Prior to February 1, 1996, the commissioner of health shall calculate the results of the statewide total of health care facility

1996 statewide target percentage is at least two percentage points higher than the statewide base percentage, the 1996 statewide reduction percentage shall be zero.

(c) If the 1997, 1998, 2000, 2001, 2002, [and] 2003, 2004 and 2005 statewide target percentages are not for each year at least three percentage points higher than the statewide base percentage, the commissioner of health shall determine the percentage by which the statewide target percentage for each year is not at least three percentage points higher than the statewide base percentage. The percentage calculated pursuant to this paragraph shall be called the 1997, 1998, 2000, 2001, 2002, [or] 2003, 2004 or 2005 statewide reduction percentage respectively. If the 1997, 1998, 2000, 2001, 2002, [or] 2003, 2004 or 2005 statewide target percentage for the respective year is at least three percentage points higher than the statewide base percentage, the statewide reduction percentage for the respective year shall be zero.

(d) If the 1999 statewide target percentage is not at least two and one-quarter percentage points higher than the statewide base percentage, the commissioner of health shall determine the percentage by which the 1999 statewide target percentage is not at least two and one-quarter

percentage points higher than the statewide base percentage. The percentage calculated pursuant to this paragraph shall be called the 1999 statewide reduction percentage. If the 1999 statewide target percentage is at least two and one-quarter percentage points higher than the statewide base percentage, the 1999 statewide reduction percentage shall be zero.

(4) (a) The 1995 statewide reduction percentage shall be multiplied by thirty-four million dollars to determine the 1995 statewide aggregate reduction amount. If the 1995 statewide reduction percentage shall be zero, there shall be no reduction amount.

(b) The 1996 statewide reduction percentage shall be multiplied by sixty-eight million dollars to determine the 1996 statewide aggregate reduction amount. If the 1996 statewide reduction percentage shall be zero, there shall be no reduction amount.

(c) The 1997 statewide reduction percentage shall be multiplied by one hundred two million dollars to determine the 1997 statewide aggregate reduction amount. If the 1997 statewide reduction percentage shall be zero, there shall be no 1997 reduction amount.

(d) The 1998, 2000, 2001, 2002, [and] 2003, 2004 and 2005 statewide reduction percentage shall be multiplied by one hundred two million dollars

respectively to determine the 1998, 2000, 2001, 2002, [or] 2003, 2004 or 2005 statewide aggregate reduction amount. If the 1998, 2000, 2001, 2002, [or] 2003, 2004 or 2005 statewide reduction percentage shall be zero respectively, there shall be no 1998, 2000, 2001, 2002, [or] 2003, 2004 or 2005 statewide reduction amount.

(e) The 1999 statewide reduction percentage shall be multiplied by seventy-six million five hundred thousand dollars to determine the 1999 statewide aggregate reduction amount. If the 1999 statewide reduction percentage shall be zero, there shall be no 1999 reduction amount.

(5) (a) The 1995 statewide aggregate reduction amount shall be allocated by the commissioner of health among residential health care facilities that are eligible to provide services to Medicare beneficiaries and residents eligible for payments pursuant to title 11 of article 5 of the social services law on the basis of the extent of each facility's failure to achieve a one percentage point increase in the 1995 target percentage compared to the base percentage, calculated on a facility specific basis for this purpose, compared to the statewide total of the extent of each facility's failure to achieve a one percentage point increase in the 1995 target percentage compared to the base percentage. This amount shall be called the 1995 facility specific reduction amount.

(b) The 1996, 1997, 1998, 1999, 2000, 2001, 2002, [and]

2003, 2004 and 2005 statewide aggregate reduction amounts shall for each year be allocated by the commissioner of health among residential health care facilities that are eligible to provide services to Medicare beneficiaries and residents eligible for payments pursuant to title 11 of article 5 of the social services law on the basis of the extent of each facility's failure to achieve a two percentage points increase in the 1996 target percentage, a three percentage point increase in the 1997, 1998, 2000, 2001, 2002, [and] 2003, 2004 and 2005 target percentage and a two and one-quarter percentage point increase in the 1999 target percentage for each year, compared to the base percentage, calculated on a facility specific basis for this purpose, compared to the statewide total of the extent of each facility's failure to achieve a two percentage points increase in the 1996, a three percentage point increase in the 1997, and a three percentage point increase in the 1998 and a two and one-quarter percentage point increase in the 1999 target percentage and a three percentage point increase in the 2000, 2001, 2002, [and] 2003, 2004 and 2005 target percentage compared to the base percentage. These amounts shall be called the 1996, 1997, 1998, 1999, 2000, 2001, 2002, [and] 2003, 2004 and 2005 facility specific reduction amounts respectively.

(6) The facility specific reduction amounts shall be due to

(g) For reimbursement of services provided to patients for the period April 1, 1995 through December 31, 1995, the trend factors established in accordance with subdivisions (d), (e) and (f) of this section shall reflect no trend factor projections applicable to the period January 1, 1995 other than those reflected in 1994 rates of payment and provide further, that this subdivision shall not apply to use of the trend factor for the January 1, 1995 through December 31, 1995 period, any interim adjustment to the trend factor for such period, or the final trend factor for such period for purposes of projection of allowable operating costs to subsequent rate periods. The Commissioner of Health shall adjust such rates of payment to reflect the exclusion of trend factor projections pursuant to this subdivision. For reimbursement of services provided to patients effective April 1, 1996 through March 31, 1997, the rates will be established by the Commissioner of Health without trend factor adjustments, but shall include the full or partial value of the retroactive impact of trend factor final adjustments for prior periods.* For reimbursement of services provided to patients on and after April 1, 1996 through March 31, 1999 and for payments made on and after July 1, 1999 through March 31, [2003] 2005, the rates shall reflect no trend factor projections or adjustments for the period April 1, 1996 through March 31, 1997.

Effective July 1, 1994, payment rates for the 1994 rate setting cycle will be calculated using the proxy data described in this section that is available through the third quarter of 1993. Proxy data which becomes available subsequent to the third quarter of 1993 will not be considered in setting or adjusting 1994 payment rates.

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*This means that since the rates for the April 1, 1996 through March 31, 1997 period are based on 1983 base year costs trended to this period, the rate impacts of any differences between, say, the final value of the 1995 trend factor and the preliminary 1995 trend factor value that may have been used when initially calculating the rate, would be incorporated into the rates for the April 1, 1996 through March 31, 1997 rate period.

**Appendix I**
**2002 Title XIX State Plan**
**Second Quarter Amendment**
**Long Term Care Services**